OPENING STATEMENT*

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BEFORE *this* audience there is no need to dwell upon the vital importance and timeliness of the subject of today's symposium. Generally speaking, the problem of combining good clinical teaching with good patient care is an age old one. Various aspects of this problem have been addressed before by interested groups, official committees, and special task forces.

With regard to the specific problem of residency training, permit me to cite from the *1978–1979 Directory of Residency Training Programs,* accredited by the Liaison Committee on Graduate Medical Education and published by the American Medical Association. On page 11 of this Directory, Residency Training is defined as follows:

> Residencies in the clinical divisions of medicine, surgery, and other special fields provide advanced training in preparation for the practice of a specialty. While the educational program is supplementary to the primary purpose of the hospital, i.e., the care and management of patients, it is directly related to this function in that it serves to improve the quality of medical care offered.

While one should have no difficulty in endorsing this statement, it is abundantly clear that the success of residency training programs depends strictly upon the fulfillment of specific conditions which encompass competence, close collaboration of all parties involved, and clearly defined sharing of responsibilities—aspects to be aired in today's symposium.

Failure to achieve these conditions in a residency training program or, worse, conflicts arising out of the divergent interests and goals of the resident and the attending physician and his patient, cannot but interfere both with good patient care and with good education.

Because of the rise and predominance of third party payment, this symposium will, of necessity, focus upon private patients, and will have to

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deal with the fact that in today's world of consumerism and of news-media saturation exposure, a well-informed public will watch for, and justly insist upon, strictest observance of the privileges and legal rights of the patient.

More specifically, a number of situations and practices (or shall I say malpractices) in the case of hospitalized private patients have the potential of creating serious difficulties and misunderstandings. The most obvious of these that come to mind are:

1) Neglect clearly to inform patients about the role of the physician-in-training

2) Assignment of tasks to residents which exceed their training, especially in surgery, and inadequate supervision by the attending physician

3) Increasing the authority and responsibility granted to residents, such as decisions about treatment and the writing of orders, which may bring residents into conflict with attending physicians.

In a nutshell, then, this symposium will be concerned with the rights of patients, with the responsibilities and privileges of physicians-in-training, with the authority and obligations of attending physicians, and, finally, the overall responsibilities of the hospital administration. Discussion of these aspects is bound to shed light on the relation between improved medical care and the quality of graduate medical education.

I am sure that you share my hope that the panel of distinguished experts whom we have been fortunate to convene here today may, perhaps, come up with suggestions for generally acceptable guidelines to insure that present and future residency training programs in teaching hospitals will maintain both excellence of teaching and high standards of patient care.